childhood hypertension over 20 years ago. Furthermore, the sounds produced during auscultatory blood pressure measurement are heard better with the bell side.

However, sometimes the solution of one problem creates another. With little or no pressure on the bell side, there frequently is some space left between the arm surface and the stethoscope because of the irregularity of the arm surface. Consequently, the sounds are either very faint or not audible at all. Use of the diaphragm side eliminates this problem and I am now using the diaphragm side.

Dr Meth's suggestion that a study be made comparing the bell versus the diaphragm with light pressure is a pertinent one. I have tested this a few times and have found the same lowering effect on the diastolic reading when firm pressure is applied to the diaphragm side. This needs documentation with measured amounts of pressure.

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Medicare's Future

TO THE EDITOR: It was with dismay that I read your editorial entitled "Medicare—Progressively Overburdened and Underfunded" in the September 1984 issue.[1]

Your reference to Victor Fuchs's observations were both interesting and relevant to the discussion of Medicare's future. Fuchs observed that in 1935 "when the age of eligibility for social security retirement benefits was set at 65, life expectancy at age 65 was about what it is now at age 72."

Unfortunately, your editorial's ensuing support for a redefinition of old age and Medicare eligibility to age 72 overlooked several critical issues:

- In today's society, there is a tendency for people to retire earlier, making it far more difficult for the aged to pay the high cost of adequate health care. And, let us not forget that with today's retirement also comes a loss of costly private health insurance.
- Rolling Medicare eligibility back to age 72 would extract a terrible price in human suffering for those unable to pay the price of needed health care.

While an eligibility roll-back may keep Medicare solvent, it would not preserve the intent of the 1965 legislation, nor solve the underlying problems Medicare was established to address. Your references to an "emotional hue and cry" and to "special-interest groups" in speaking of the opposition to a proposed roll-back serve only to cloud these underlying issues.

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More on Pains Cured by Examination

TO THE EDITOR: Recent discussions with colleagues concerning cure of pelvic and abdominal pain through pelvic examination[1,2] have elicited another hypothesis and an intriguing case history.

The hypothesis is that partial torsion of a relatively mobile structure, such as sigmoid colon or ovary, might underlie some cases, and might be relieved after the simple manipulation inherent in examination.

The case concerns a 44-year-old internist, previously and afterwards healthy, in whom sudden, severe and unremitting right lower quadrant pain developed, which radiated to groin and vulva. Upon light abdominal palpation by a colleague, the pain remitted abruptly; urinary urgency followed, with painless passage of a stone. The apparent mechanism of pain relief was migration of a urolith, probably ureteral. The timing suggests a relationship between the events; however, the deep retroperitoneal location of the ureter should prevent effective transmission of surface pressures, especially slight ones, and alternative explanations (unrelated events, or events related by unknown means) cannot be dismissed. If several other cases were reported, the entity of "examination-assisted stone migration" might be established no matter how obscure its mechanism.

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Preoperative Evaluations

TO THE EDITOR: Levinson's report in the September issue[1] on the value of preoperative evaluations by an internist does not suggest, as Abrams concludes in the accompanying editorial, "a well-founded basis for the routine preoperative evaluation for patients undergoing eye surgery in a general community hospital."[1,2] In fact, the study is fundamentally flawed and unable to support any important conclusions regarding the question at hand.

First, whether a patient received a preoperative visit by an internist "was determined by the ophthalmologist." Consultations were performed on 258 patients, but we are told nothing specific about the cases for which consultation was not requested. Without at least minimal information regarding this group, one cannot possibly justify any conclusions regarding the value of *routine* preoperative evaluations.

Second, the benefit is questionable even in the selected patients who received a preoperative evaluation. We are told that 51/258 patients had "conditions considered important to surgical risk," but the literature cited to justify these conditions as risk factors is derived mostly from studies of patients undergoing general anesthesia for general surgery. The relevance of these supposed risks to ophthalmological surgery is unclear, especially since eye patients commonly receive only local anesthesia and mild sedation during their operations. Further, assignment of risk factors to individual patients was apparently subjective in many instances. For example, 26/59 risk factors cited were "severe chronic lung disease" or "severe asthma." No objective data are presented to justify the assessment of severity in these patients; the internists' impressions are simply taken at face value.

Even if we grant that many true risk factors were discovered, was this of any benefit to the patients? Only five actual

interventions are described, and their worth is open to debate. For example, does the attempt to "correct" severe hypokalemia over only one day before surgery really reduce perioperative morbidity? In any case, one does not establish the value of 258 consultations simply by describing a few such episodes.

Finally, even if we are convinced that benefit may derive from the discovery of the risk factors cited by Levinson, is it really necessary to call in an internist to do the sleuthing? Let us excuse the ophthalmologist for his or her presumed inability to recognize any problems residing outside the orbit, but what of the anesthesiologist? Remarkably enough, Levinson never specifies what type of anesthesia was administered (that is, local versus general), whether an anesthesiologist was present during surgery or whether a preoperative anesthesiologist's visit was made. If, as is true in many hospitals, most eye surgery patients have "local standby" anesthesia (local anesthesia with an anesthesiologist present to provide sedation, monitoring and general anesthesia should it become necessary), good anesthetic practice would require a preoperative visit. Is it not conceivable that the anesthesiologist might perceive that the patient suffers from severe lung disease, atrial fibrillation or hypokalemia? It is difficult to credit Levinson's cost-benefit analysis for the internists' consultations when the possible contribution of the anesthesiologist is entirely ignored. Dr Abrams laments the "narrow focus of specialists in medicine." Indeed.

Although Levinson has attempted to shed light on an important area of medical practice, this study unfortunately obfuscates more than it illuminates. The data fail to demonstrate the benefit of preoperative medical consultation even in her selected study population, let alone justify the conclusion put forth by both Levinson and Abrams that routine consultation in eye surgery patients over age 50 is warranted.

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Dr Levinson Replies

TO THE EDITOR: In response to comments by Dr Bryan Bohman about my article "Preoperative Evaluations by an Internist—Are They Worthwhile?", I would respond with the following.

My study was not attempting to *prove* that routine consultations by internists resulted in decreased morbidity or mortality to patients. Clearly a randomized controlled study addressing this subject would be most difficult to perform. However, in practice many ophthalmologists *do* obtain the advice of an internist before surgery and this study informs the reader about what the internists actually discovered. Objective criteria were used to evaluate risk factors including chronic lung disease whenever documentation was available and interventions were made for 39 of those 59 risk conditions. Of these surgeries, 95% were done under general anesthesia.

It is true that the anesthesiologist might have discovered and treated some of these conditions and hence the internist's help was redundant. However, overall in reviewing the number of significant risk conditions and incidental findings found by an internist, I conclude that these evaluations are warranted in patients older than 50 years. I suspect that appropriate interventions for risk conditions led to decreased morbidity and perhaps mortality in some cases. Furthermore, the cost of the consultation is very small relative to the cost of surgical procedures.

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Dr Abrams Replies

TO THE EDITOR: A careful reading of my comments on the Levinson article suggests that my conclusion is not as sanguine regarding Dr Levinson's thesis as Dr Bohman believes. While concurring "that routine interventions . . . should be limited only to those persons older than 50," I also go on to say that greater cost-effectiveness could have been achieved if the ophthalmologist had called for consultation in only those patients with *significant surgical risk* . . . ." In my analysis of the serious complications I stressed that only 1 of 11 major complications was even remotely affected by the internist's preoperative evaluation, and in that case (of rapid atrial fibrillation) postoperative intervention still was not necessary.

Dr Levinson's recommendation of a routine internist evaluation in patients over 50 derived from her discovery of significant risk factors present in approximately one out of five persons over 50 and the unclear nature of nonophthalmologic care of these patients. She makes the case that the costs involved were quite modest, compared with the cost of the surgery (and, presumably, anesthesia as well).

With respect to Dr Bohman's point regarding the patients in whom a consultation was not requested, one would assume that these were persons free of any overt risk after the history and physical were carried out by the ophthalmologist. These patients may have had recent clearance from their own physicians.

I still feel that Dr Levinson's contribution is worthwhile, in that it focuses on a little-addressed area in medical literature. Dr Bohman's criticisms are for the most part well taken, but I would prefer to view them in the nature of a continuing dialogue regarding the necessity for preoperative evaluations. More data are required. My editorial conclusion remains intact: "one wonders if good common sense and attention to details might not be even more cost-effective than calling internists in routinely."

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